IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK– ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

May 19, 2017

James Elton, Administrator
Wellspring Health & Rehabilitation of Cascadia
2105 12th Avenue Road
Nampa, ID 83686-6312

Provider #: 135094

RE: **FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER**

Dear Mr. Elton:

On **May 10, 2017**, a Facility Fire Safety and Construction survey was conducted at **Wellspring Health & Rehabilitation of Cascadia** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date to signify when

you allege that each tag will be back in compliance. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 31, 2017**. Failure to submit an acceptable PoC by **May 31, 2017**, may result in the imposition of civil monetary penalties by **June 20, 2017**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **June 14, 2017**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **June 14, 2017**. A change in the seriousness of the deficiencies on **June 14, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 14, 2017**, includes the following:

Denial of payment for new admissions effective **August 10, 2017**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 10, 2017**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 10, 2017**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **May 31, 2017**. If your request for informal dispute resolution is received after **May 31, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2017
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135094 | A. BUILDING 01 - ENTIRE BUILDING<br>B. WING _____ | 05/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLSPRING HEALTH & REHABILITATION OF CASCADIA | 2105 12TH AVENUE ROAD<br>NAMPA, ID 83686 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>The facility is a single story Type V (III) structure built in 1998 with an addition of 60 beds in March 2001. The facility is sprinklered throughout with smoke detection coverage in corridors, sleeping rooms, and open spaces. The facility is currently licensed for 120 SNF/NF beds.<br><br>The following deficiencies were cited during the annual fire/life safety survey conducted on May 9 - 10, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.<br><br>The Survey was conducted by:<br><br>Linda Chaney<br>Health Facility Surveyor<br>Facility Fire Safety & Construction | K 000 | | |
| K 325 SS=F | NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)<br><br>Alcohol Based Hand Rub Dispenser (ABHR)<br>ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:<br>* Corridor is at least 6 feet wide<br>* Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols<br>* Dispensers shall have a minimum of 4-foot horizontal spacing<br>* Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room<br>* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 | K 325 | 325- Alcohol Based Hand Rub Dispenser.<br><br>Maintenance Director and House Keeping Director were educated on NFPA 325 on testing ABHR upon dispenser refill. May 11, 2017<br><br>House Keeping Director educated staff on process to test hand sanitizers upon refill and document completion. The units will be numbered and logged for each change May 17, 2017<br><br>Quarterly QA meeting to review Documentation Quarterly for completion of ABHR unit testing. | May 17 |

RECEIVED
JUN 01 2017
FACILITY STATE

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | NHA | 5/31/17 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| K 325 | Continued From page 1<br>* Dispensers are not installed within 1 inch of an ignition source<br>* Dispensers over carpeted floors are in sprinklered smoke compartments<br>* ABHR does not exceed 95 percent alcohol<br>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)<br>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>This STANDARD is not met as evidenced by:<br>Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed could result in inadvertently spilling flammable liquids, increasing the risk of fires. This deficient practice affected 59 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF residents and had a census of 59 on the day of the survey.<br><br>Findings include:<br><br>During the review of facility inspection records conducted on May 9, 2017 from approximately 9:00 AM to 1:00 PM, no records were available indicating ABHR dispensers were tested in accordance with manufacturer's care and use instructions when a new refill is installed. ABHR dispensers were observed throughout the facility and when asked, the Maintenance Director stated the facility was not aware of the requirement to test ABHR dispensers each time a new refill is installed. | K 325 | | |

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| K 325 | Continued From page 2<br>Actual NFPA standard:<br><br>NFPA 101<br><br>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:<br>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).<br>(2) The maximum individual dispenser fluid capacity shall be as follows:<br>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors<br>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms<br>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.<br>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in (1220 mm).<br>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).<br>(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).<br>(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the | K 325 | | |

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| K 325 | Continued From page 3<br>requirements of NFPA 30, Flammable and Combustible Liquids Code.<br>(8) Dispensers shall not be installed in the following locations:<br>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source<br>(b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source<br>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source<br>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.<br>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.<br>(11) Operation of the dispenser shall comply with the following criteria:<br>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.<br>(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.<br>(c) An object placed within the activation zone and left in place shall not cause more than one activation.<br>(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.<br>(e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized.<br>(f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed. | K 325 | | |

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| K 331 SS=E | NFPA 101 Interior Wall and Ceiling Finish<br><br>Interior Wall and Ceiling Finish<br>2012 EXISTING<br>Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted.<br>10.2, 19.3.3.1, 19.3.3.2<br>Indicate flame spread rating(s).<br><br>This STANDARD is not met as evidenced by:<br>Based on record review, observation and interview, the facility failed to ensure the interior finish limitations were of Class A or Class B. Failure to provide flame spread rating documentation and ensure the flame resistive properties of interior wall finishes could inhibit the spread of fire over the continuous surface forming the interior portions of a building. This deficient practice affected 59 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 59 on the day of the survey.<br><br>Findings include:<br><br>During review of the facility records conducted on May 9, 2017 from approximately 9:00 AM to 1:00 PM, the facility failed to provide documentation of the flame resistive properties of the wall covering in the Theatre room and below the hand rail in the main corridor. Further physical observation revealed the wall covering to be "carpet like". When asked, the Maintenance Director stated the wall covering had been in place since he took his position with the facility and he was not aware of | K 331 | K331- Interior Wall Finish<br><br>Maintenance Director will spray curtains in Theater room, carpet-like wall treatments in main hall, with certified Flame retardant June 1, 2017.<br><br>Maintenance Director will audit facility to identify other textiles on walls and ceilings requiring treatment and treat each case individually.<br><br>Maintenance Director will document completion of Treatments, and routinely audit facility for like materials. Per manufacturer guidelines, Maintenance Director will repeat treatments annually, or after deep cleaning of said materials. June 2 | |

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| K 331 | Continued From page 5<br>its origin or flammability rating.<br><br>Actual NFPA standard:<br><br>NFPA 101<br>19.3.3 Interior Finish.<br>19.3.3.1 General. Interior finish shall be in accordance with Section 10.2.<br><br>10.2.4.1* Textile Wall and Textile Ceiling Materials. The use of textile materials on walls or ceilings shall comply with one of the following conditions:<br>(1) Textile materials meeting the requirements of Class A when tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials, or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials, using the specimen preparation and mounting method of ASTM E 2404, Standard Practice for Specimen Preparation and Mounting of Textile, Paper or Vinyl Wall or Ceiling Coverings to Assess Surface Burning Characteristics (see 10.2.3.4), shall be permitted on the walls or ceilings of rooms or areas protected by an approved automatic sprinkler system.<br>(2) Textile materials meeting the requirements of Class A when tested in accordance with ASTM E 84 or ANSI/UL 723, using the specimen preparation and mounting method of ASTM E 2404 (see 10.2.3.4), shall be permitted on partitions that do not exceed three-quarters of the floor-to-ceiling height or do not exceed 8 ft (2440mm) in height, whichever is less.<br>(3) Textile materials meeting the requirements of Class A when tested in accordance with ASTM E 84 or ANSI/UL 723, using the specimen | K 331 | | |

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| K 331 | Continued From page 6<br>preperation and mounting method of ASTM E 2404 (see 10.2.3.4), shall be permitted to extend not more than 48 in. (1220 mm) above the finished floor on ceiling-height walls and ceiling-height partitions.<br>(4) Previously approved existing installations of textile material meeting the requirements of Class A when tested in accordance with ASTM E 84 or ANSI/UL 723 (see 10.2.3.4) shall be permitted to be continued to be used.<br>(5) Textile materials shall be permitted on walls and partitions where tested in accordance with NFPA 265, Standard Methods of Fire Tests for Evaluating Room Fire Growth Contribution of Textile or Expanded Vinyl Wall Coverings on Full Height Panels and Walls. (See 10.2.3.7.)<br>(6) Textile materials shall be permitted on walls, partitions, and ceilings where tested in accordance with NFPA 286, Standard Methods of Fire Tests for Evaluating Contribution of Wall and Ceiling Interior Finish to Room Fire Growth. (See 10.2.3.7.) | K 331 | | |
| K 353 SS=F | NFPA 101 Sprinkler System - Maintenance and Testing<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____ | K 353 | K353-Sprinkler System<br><br>Sprinkler Heads in the Kitchen and Laundry will be replaced by certified contracted sprinkler specialists June 2, 2017.<br><br>The Dry Barrel sprinkler will be tested on June 2 and serviced to be in compliance.<br><br>Facility sprinklers will all be checked by Maintenance Director to ensure heads have neither corrosion nor paint on them. This will be repeated monthly and reported at the Quarterly QA meeting.<br>June 2 '17 | |

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|---|---|---|---|---|
| K 353 | Continued From page 7<br>c) Water system supply source<br><br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This STANDARD is not met as evidenced by:<br>Based on record review, observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants can have a detrimental effect on the performance of sprinklers by affecting water distribution patterns, insulating thermal elements, delaying operation, or otherwise rendering the sprinkler inoperable or ineffectual. This deficient practice affected 59 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 59 on the day of the survey.<br><br>Findings include:<br><br>1.) During record review on May 9, 2017, from approximately 9:00 AM to 1:00 PM, an annual fire sprinkler inspection document dated June 6, 2016 identified the following deficiencies:<br>a.) Obstructed sprinkler heads due to paint or corrosion in the kitchen and laundry.<br>b.) The dry barrel sprinkler heads needed to be tested or replaced.<br>No documentation that the deficiencies had been corrected could be produced.<br>2.) Further observation during the facility tour on May 9, 2017, from approximately 1:00 PM to 4:30 PM revealed the following:<br><br>a.) Eight (8) painted sprinkler heads in the | K 353 | | |

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|---|---|---|---|
| | 136094 | A. BUILDING 01 - ENTIRE BUILDING<br>B. WING _____ | 05/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLSPRING HEALTH & REHABILITATION OF CASCADIA | 2105 12TH AVENUE ROAD<br>NAMPA, ID 83686 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 353 | Continued From page 8<br>Kitchen.<br>b.) One (1) corroded sprinkler head in the walk in refrigerator.<br>c.) One (1) corroded sprinkler head in the Laundry.<br>d.) One (1) painted sprinkler head in the 400 Hallway Shower Room.<br>e.) One (1) painted sprinkler head in the 500 Hallway Soiled Linen Room.<br><br>Interview of the Maintenance Director revealed he was not aware of the deficiencies prior to the date of the survey.<br><br>Actual NFPA standard:<br><br>NFPA 25<br><br>5.2.1 Sprinklers.<br><br>5.2.1.1* Sprinklers shall be inspected from the floor level annually.<br><br>5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).<br><br>5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:<br>(1) Leakage<br>(2) Corrosion<br>(3) Physical damage<br>(4) Loss of fluid in the glass bulb heat responsive element<br>(5)*Loading<br>(6) Painting unless painted by the sprinkler manufacturer | K 353 | | |

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| K 751 SS=E | NFPA 101 Draperies, Curtains, and Loosely Hanging Fabr<br><br>Draperies, Curtains, and Loosely Hanging Fabrics<br>Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall.<br>18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1<br>This STANDARD is not met as evidenced by:<br>Based on record review, observation and interview, the facility failed to ensure the flame resistive properties of loosely hanging curtains. Failure to provide flame spread ratings and ensure the flame resistive properties of loosely hanging curtains could add to the growth and spread of fire during a fire event. This deficient practice affected 34 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 59 on the day of the survey.<br><br>Findings include:<br><br>During review of the facility records conducted on May 9, 2017 from approximately 9:00 AM to 1:00 PM, no documentation was provided for the curtains hanging floor to ceiling along the wall in the Theatre Room. Further physical observation revealed the curtains to be fabric yardage, without labeling to indicate flammability rating.<br><br>Upon further calculation of the Theatre Room appeared the curtains exceeded 20 percent of the | K 751 | K751- Drapes/Curtains<br><br>Maintenance Director sprayed curtains in Theater room, carpet-like wall treatments in main hall, with certified Flame retardant June 1, 2017.<br><br>Maintenance Director will audit facility to identity other textiles on walls and ceilings requiring treatment and treat each case individually.<br><br>Maintenance Director will document completion of treatments, and routinely audit facility for like materials. Per manufacturer guidelines, maintenance Director will repeat treatments annually, June 1 or after deep cleaning of said materials. | |

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| K 751 | Continued From page 10<br>aggregate area of the wall on which they were located.<br><br>When asked if the facility had applied any type of flame retardant to the curtains, the Maintenance Director stated he was not aware of any.<br><br>Actual NFPA standard:<br><br>NFPA 101<br>19.7.5.1* Draperies, curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the provisions of 10.3.1 (see 19.3.5.11), and the following also shall apply:<br>(1) Such curtains shall include cubicle curtains.<br>(2) Such curtains shall not include curtains at showers and baths.<br>(3) Such draperies and curtains shall not include draperies and curtains at windows in patient sleeping rooms in smoke compartments sprinklered in accordance with 19.3.5.<br>(4) Such draperies and curtains shall not include draperies and curtains in other rooms or areas where the draperies and curtains comply with all of the following:<br>(a) Individual drapery or curtain panel area does not exceed 48 ft2 (4.5 m2).<br>(b) Total area of drapery and curtain panels per room or area does not exceed 20 percent of the aggregate area of the wall on which they are located.<br>(c) Smoke compartment in which draperies or curtains are located is sprinklered in accordance with 19.3.5<br><br>10.3 Contents and Furnishings.<br>10.3.1* Where required by the applicable | K 751 | | |

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| K 751 | Continued From page 11<br>provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall meet the flame propagation performance criteria contained in NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. | K 751 | | |
| K 927 SS=D | NFPA 101 Gas Equipment - Transfilling Cylinders<br><br>Gas Equipment - Transfilling Cylinders<br>Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)<br>This STANDARD is not met as evidenced by:<br>Based on observation and operational testing, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Failure to transfill liquid oxygen with mechanical ventilation could result in creating a oxygen rich environment, increasing the potential for combustion. This deficient practice affected 19 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 59 on the day of the survey.<br><br>Findings include:<br><br>During the facility tour conducted on May 9, 2017 from approximately 1:00 PM to 4:30 PM, | K 927 | K 927- Gas Filling Equipment<br><br>Maintenance Director repaired the fan for oxygen transfill area on May 12. There are no other oxygen filling transfill areas..<br><br>Oxygen fill area doors will be checked quarterly for circulatory function and reported at the facilities Annual QA meeting. | May 12 |

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| K 927 | Continued From page 12<br>observation and operational testing of the fan for the oxygen storage/transfill area revealed the fan was not operational.<br><br>Actual NFPA standard:<br><br>NFPA 99<br><br>11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable.<br>11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following:<br>(1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction.<br>(2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring.<br>(3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted.<br>(4) The individual transfilling the container(s) has been properly trained in the transfilling procedures.<br><br>9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm). | K 927 | | |